

<b>Physician:</b> _____ <b>Phone:</b> _____	<b>Billing Option:</b> Bill Physician <input type="checkbox"/> Bill Patient <input type="checkbox"/>	<b>Results Option:</b> Email <input type="checkbox"/> Fax <input type="checkbox"/>	Request faxed to Brittany Hart at 801-294-1381 on _____ / ____ / ____
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Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Gender: M  F

<b>Draw Instructions</b> In Office Kit Used <input type="checkbox"/> Send kit to patient, refer to a draw site <input type="checkbox"/>	<b>NOTE</b> - A \$35.00 shipping fee is applied to each order. - If we are billing patients, please provide their payment information to avoid shipping delays.
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**MALE INITIAL PANEL I**  
 CBC/Chemistry with Lipids  
 DHEA Sulfate  
 Free T3/Free T4/TSH  
 Somatomedin-C  
 Testosterone F&T  
 PSA F&T

**MALE INITIAL PANEL II**  
*Male Initial Panel I Plus:*  
 Estradiol, DHT  
 Vit D-25 Hydroxy

**MALE COMPREHENSIVE**  
*Male Initial Panel II Plus:*  
 Insulin, Hemoglobin A1C  
 Homocysteine, Cardio CRP  
 Lipo (a), Vit D-25 Hydroxy

**MALE F/U PANEL I**  
 DHEA Sulfate  
 Free T3/Free T4/TSH  
 Testosterone F & T  
 PSA F&T

**MALE F/U PANEL II**  
*Male Follow up I Plus:*  
 Estradiol, DHT  
 Vit D-25 Hydroxy

**MALE MASTER**  
*Male Comprehensive Plus:*  
 LH / Cortisol Total

**FEMALE INITIAL PANEL I**  
 CBC/Chemistry with Lipids  
 Estradiol/Progesterone  
 DHEA Sulfate  
 Free T3/FreeT4/TSH  
 Somatomedin-C  
 Testosterone F&T

**FEMALE INITIAL PANEL II**  
*Female Initial Panel I Plus:*  
 Vit D-25 Hydroxy

**FEMALE COMPREHENSIVE**  
*Female Initial Panel II Plus:*  
 Insulin, Hemoglobin A1C  
 Homocysteine, Cardio CRP  
 Lipo (a), Vit D-25 Hydroxy

**FEMALE F/U PANEL I**  
 Estradiol  
 Progesterone  
 DHEA Sulfate  
 Free T3/Free T4/TSH  
 Testosterone F&T

**FEMALE F/U PANEL II**  
*Female Follow Up Panel I Plus:*  
 Somatomedin-C  
 Vit D-25 Hydroxy

**FEMALE MASTER**  
*Female Comprehensive Plus:*  
 LH / FSH  
 Cortisol Total

### Individual Tests Billed Separately

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> ACTH Plasma             | <input type="checkbox"/> Homocysteine         | <input type="checkbox"/> NTX, urine         | <input type="checkbox"/> Magnesium       |
| <input type="checkbox"/> CBC                     | <input type="checkbox"/> LH                   | <input type="checkbox"/> Cardio CRP         | <input type="checkbox"/> Vitamin B12     |
| <input type="checkbox"/> Chemistry /HDL/LDL/VLDL | <input type="checkbox"/> Lipid Profile        | <input type="checkbox"/> C-Reactive Protein | <input type="checkbox"/> Ferritin        |
| <input type="checkbox"/> Cortisol                | <input type="checkbox"/> Progesterone         | <input type="checkbox"/> Hemoglobin A1C     | <input type="checkbox"/> Fasting Insulin |
| <input type="checkbox"/> DHEA Sulfate            | <input type="checkbox"/> Prolactin            | <input type="checkbox"/> Calcium, Ionized   | <input type="checkbox"/> SHBG            |
| <input type="checkbox"/> Dihydrotestosterone     | <input type="checkbox"/> PSA                  | <input type="checkbox"/> 17 Hydroxy Preg    | Other:                                   |
| <input type="checkbox"/> Estradiol               | <input type="checkbox"/> PSA, F& T            | <input type="checkbox"/> Vit D-25 Hydroxy   | <input type="checkbox"/> _____           |
| <input type="checkbox"/> Free T3/Free T4/TSH     | <input type="checkbox"/> Somatomedin-C        | <input type="checkbox"/> CA 15-3            | <input type="checkbox"/> _____           |
| <input type="checkbox"/> FSH                     | <input type="checkbox"/> Testosterone F and T | <input type="checkbox"/> Heavy Metals       | <input type="checkbox"/> _____           |
| <input type="checkbox"/> Folate                  | <input type="checkbox"/> Hemoglobin A1C       |   |  |

*I authorize MedQuestTesting Services (MTS) as my agent to order these tests and receive results I also request a copy of the results be sent to my office as confirmation.*

Signature \_\_\_\_\_

Physician signature

**MedQuest Testing Services**

669 West 900 North  
North Salt Lake City, UT. 84054  
Toll Free: 888-556-5567  
Direct: 801-294-1436  
Fax: 801-294-1381

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**CREDIT CARD AUTHORIZATION:**

Lab work is prepaid. If you need pricing information, please contact MTS at 888-556-5567.

- Visa
- Mastercard
- American Express
- Discover

Card No.:

Expiration Date: \_\_\_\_\_ / \_\_\_\_\_ Amount: \_\_\_\_\_

Name of Cardholder: \_\_\_\_\_

I hereby authorize MedQuest Testing Services to charge my credit card for the cost of lab work.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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**CHECK INFORMATION:** Make checks payable to **MedQuest Testing Services. NO CASH!**

Check Paid:  Date: Check #: Amount:

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**PATIENT AUTHORIZATION FOR RELEASE OF  
LABORATORY TEST RESULTS**

Physician Name: \_\_\_\_\_

Patient Name: (Please Print)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Last First Middle Date

I hereby authorize Quest Diagnostics and duly authorized agents and employees to release information pertaining to my medical laboratory testing to MedQuest Testing Services (MTS). I understand that Quest Diagnostics and its directors, officers, employees or agents cannot be responsible for confidentiality of testing information once such information is released by this authorization and I hereby release them from any liability arising from such disclosure. All results released by MTS will be kept confidential.

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Signature of Patient Date